Resident Name:	**Resident Number:**	**Effective Date:**	
Date of Birth:	**Gender:**	**Title:**	Nursing Assessment - Initial (Admission) v2
Type:	**Facility Name:**		

A. General

1.	**Informant**	Check all that apply: **a.** ☐ Patient **b.** ☐ Family/Significant Other **c.** ☐ Chart **d.** ☐ Other **d1.** If Other, please specify
2.	**Call Bell / Physician Notification**	**1.** Call bell placed within reach. **2.** Physician notified of admission/readmission and orders verified? ○ 0. Yes ○ 1. No **2a.** If no, explain
3.	**Reason for Admission**	Check all that apply: **a.** ☐ Exacerbation of chronic illness **b.** ☐ Post-surgery **c.** ☐ Recent acute illness **d.** ☐ Post trauma/Accident **e.** ☐ Long Term Care **f.** ☐ Hospice **g.** ☐ Rehabilitation **h.** ☐ Other **h1.** If Other, explain
4.	**Modes of Transportation**	**a.** How did the patient arrive? 1) Ambulance 2) Private car 3) Wheelchair van 4) Taxi 5) Other **b.** Via 1) Stretcher 2) Wheelchair 3) Ambulating
5_.	**General Comments**	

B. Health History

1.	**Conditions Affecting Interim Care Planning**	Check all that apply: **a.** ☐ Diabetes Mellitus **b.** ☐ Cardiac Disease

1.	**Conditions Affecting Interim Care Planning**	Check all that apply: c. ☐ Hypertension d. ☐ Hypotension e. ☐ Peripheral Vascular Disease (PVD) f. ☐ CVA g. ☐ Pulmonary Disease h. ☐ Vertigo i. ☐ Parkinson's j. ☐ Seizure Disorder k. ☐ End stage disease (6 or fewer months to live)
2.	**Infections Requiring Interim Care Planning**	Check all that apply: a. ☐ UTI b. ☐ Respiratory/Pneumonia c. ☐ C Diff d. ☐ MRSA e. ☐ VRE f. ☐ other MDRO f1. If other MDRO, specify:
3.	**Falls**	**Fall History on Admission** F_a1. Did the resident have a fall any time in the last month prior to admission? ○ 0. No ○ 1. Yes ○ 9. Unable to determine ○ -. Not assessed F_a2. Did the resident have a fall any time in the last 2-6 months prior to admission? ○ 0. No ○ 1. Yes ○ 9. Unable to determine ○ -. Not assessed a3. Did the resident have any fracture related to a fall in the 6 months prior to admission? ○ 0. No ○ 1. Yes ○ 9. Unable to determine ○ -. Not assessed
4.	**Current Substance Use**	a. Alcohol use ○ 0. No ○ 1. Yes a1. If yes, how much a2. How often b. Illicit drug use ○ 0. No ○ 1. Yes b1. If yes, indicate type

4.	Current Substance Use	Current Tobacco Use (include chewing tobacco) **c.** Tobacco use ○ 0. No ○ 1. Yes ○ -. Not assessed/no information **d.** Currently smokes ○ 0. No ○ 1. Yes
5.	Medications Requiring Interim Care Planning	**Check all the medications listed below that the resident received at any time since admission/reentry.** **a.** *Select medications according to a drug's PHARMACOLOGICAL CLASSIFICATION, not how it is used. For example, oxazepam may be used as a hypnotic, but it is classified as an antianxiety medication, so it would be selected as an antianxiety medication in this list.* **a1.** ☐ Antidepressant **a2.** ☐ Antihypertensive **a3.** ☐ AntiParkinson's **a4.** ☐ Sedative **a5.** ☐ Hypnotic **a6.** ☐ Diuretic **F_a7.** Medication Fall Risk Status 1) Not taking any of the above medications (a1 - a6) 2) Taking only one of the above medications (a1 - a6) 3) Taking two of the above medications (a1 - a6) 4) Taking three or more of the above medications (a1 - a6) **a8.** ☐ Antipsychotic **a9.** ☐ Antianxiety **a10.** ☐ Anticoagulant (warfarin, heparin, or low-molecular weight heparin) **a11.** ☐ Antibiotic
6_.	Health Care Decision Making	Review Advance Directives, if available DNR (If yes, obtain order) ○ 0. No ○ 1. Yes
7.	Allergies	Does the resident have any allergies? ○ 0. No Known Allergies (NKA) ○ 1. Yes
8.	Comments	

C. Vital Signs

1.	Temperature	Most Recent Temperature	Temperature: Date: Route:
2.	Pulse	Most Recent Pulse	Pulse: Date: Pulse Type:

3.	**Respiration**	Most Recent Respiration Respiration: Date: Check all that apply: **a.** ☐ Regular **b.** ☐ Irregular **c.** ☐ Labored **d.** ☐ Shallow
4.	**O2 Sats**	Most Recent O2 sats O2 sats: (%) Date: Method:
5.	**Blood Pressure**	**a. Lying** **a1.** Most Recent Blood Pressure Blood Pressure: / Date: Position: **b. Sitting/Standing** **b1.** Most Recent Blood Pressure Blood Pressure: / Date: Position: **c.** Orthostatic changes? ○ 0. No ○ 1. Yes ○ 3. UTD
6.	**Height & Weight**	**a_b.** NOTE: Height is measured in inches and Weight in LBS (pounds). **a.** Most Recent Height Height: Date: Method: **b.** Most Recent Weight Weight: Date: Scale: **b1.** ☐ Weight unable to be obtained due to late admission.
7.	**Pain Management**	**COMPLETE FOR ALL RESIDENTS, REGARDLESS OF CURRENT PAIN LEVEL.** **a.** Been on a scheduled pain medication regimen? ○ 0. No ○ 1. Yes ○ -. Not assessed/no information **b.** Received PRN pain medications? ○ 0. No ○ 1. Yes ○ -. Not assessed/no information **c.** Received non-medication intervention for pain? ○ 0. No ○ 1. Yes ○ -. Not assessed/no information **d.** Ask resident: "Have you had pain or hurting at any time in the last 5 days?" ○ 0. No ○ 1. Yes ○ 9. Unable to answer ○ -. Not assessed **e. If resident is unable to answer C7d. and indicators of pain or possible pain are exhibited, check all that currently apply:**

7.	Pain Management	**e1.** ☐ Non-verbal sounds (e.g., crying, whining, gasping, moaning, or groaning) **e2.** ☐ Vocal complaints of pain (e.g., that hurts, ouch, stop) **e3.** ☐ Facial expressions (e.g., grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw) **e4.** ☐ Protective body movements or postures (e.g., bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement)
8.	Comments	

D. Systems Evaluation

1.	Neurologic/Cognition	Comatose *The person is unresponsive and cannot be aroused; he or she may or may not open his or her eyes, does not speak, and does not move his or her extremities on command or in response to noxious stimuli (e.g., pain). REQUIRES PHYSICIAN DIAGNOSIS* **a.** Persistent vegetative state/no discernible consciousness ○ 0. No ○ 1. Yes ○ -. Not assessed/no information **b.** Mental Status 1) alert 2) drowsy 3) lethargic 4) confused 5) stuporous **F_c.** Oriented to: 1) Person/Place/Time 2) Person/Place (not Time) 3) Person only (not Place/Time) 4) Not oriented to Person/Place/Time Pupils: **d1.** Size 1) Equal 2) Unequal right > left 3) Unequal left > right 4) UTD **d2.** Reaction right 1) Brisk 2) Sluggish 3) UTD **d3.** Reaction left 1) Brisk 2) Sluggish 3) UTD **e.** Sensory perception (Braden) 4) No Impairment - has ability to feel pain, no paralysis 3) Slightly Limited - lack of ability to feel pain in one or two extremities 2) Very Limited - cannot feel pain over half of the body 1) Completely Limited - cannot feel pain over most of the body Behaviors requiring Care Planning (observed/reported): **F_f1.** Judgment / Insight 1) Intact 2) Mild alteration 3) Moderate alteration 4) Severe alteration **f2.** ☐ Anxiety **f3.** ☐ Rejected evaluation or care

1. Neurologic/Cognition

f4. ☐ Hallucinations (perceptual experiences in the absence of real external sensory stimuli)

f5. ☐ Agitation/Restlessness

f6. ☐ Suicidal ideation

f7. ☐ Abusive/Aggressive/Combative

f8. ☐ Sexually inappropriate

f9. ☐ Verbalizing/History of a desire to leave/exit seeking

f10. ☐ History of/Observed wandering

g. Hearing

g1. Ability to hear (with hearing aid or hearing appliances if normally used)
- ○ 0. Adequate
- ○ 1. Minimal difficulty
- ○ 2. Moderate difficulty
- ○ 3. Highly impaired
- ○ -. Not assessed

g2. Hearing aid or other hearing appliance used in completing B0200, Hearing
- ○ 0. No
- ○ 1. Yes
- ○ -. Not assessed/no information

h. Vision

h1. Ability to see in adequate light (with glasses or other visual appliances)
- ○ 0. Adequate
- ○ 1. Impaired
- ○ 2. Moderately impaired
- ○ 3. Highly impaired
- ○ 4. Severely impaired
- ○ -. Not assessed

h2. Corrective lenses (contacts, glasses, or magnifying glass) used in completing B1000, Vision
- ○ 0. No
- ○ 1. Yes
- ○ -. Not assessed/no information

Appliances/Aides - Check all that apply:

i. ☐ None

i1. ☐ Hearing aid left

i2. ☐ Hearing aid right

i3. ☐ Glasses

i4. ☐ Contact lenses

i5. ☐ Prosthetic eye

i6. ☐ Magnifying glass

j. Speech

j1. Select best description of speech pattern
- ○ 0. Clear speech
- ○ 1. Unclear speech
- ○ 2. No speech
- ○ -. Not assessed

k. Neurologic/Cognition Section Comments

1.	Neurologic/Cognition		
2.	Cardiovascular	**a.** Chest discomfort - recent history	○ 0. No ○ 1. Yes ○ 3. UTD
		b. Internal defibrillator	○ 0. No ○ 1. Yes ○ 3. UTD
		c. Pacemaker	○ 0. No ○ 1. Yes ○ 3. UTD
		Circulation	
		d1. Pedal Pulses - right	○ 1. Palpable ○ 2. Nonpalpable ○ 3. Not applicable
		d2. Pedal Pulses - left	○ 1. Palpable ○ 2. Nonpalpable ○ 3. Not applicable
		e. Edema	○ 1. Not present ○ 2. Present ○ 3. Not applicable
		e1. If present, edema location	
		Lower Extremity Color	
		f1. Right	1) Normal for ethnicity 2) Pale 3) Cyanotic / Dusky 4) Jaundiced 5) Not applicable
		f2. Left	1) Normal for ethnicity 2) Pale 3) Cyanotic / Dusky 4) Jaundiced 5) Not applicable
		Lower Extremity Temperature	
		g1. Right	○ 1. Warm ○ 2. Cool ○ 3. Not applicable
		g2. Left	○ 1. Warm ○ 2. Cool ○ 3. Not applicable
		h. Cardiovascular Section Comments	
3.	Respiratory	**Lung Sounds**	
		a. ☐ clear, all lobes	
		b. Crackles/Rales	
		b1. ☐ right upper	
		b2. ☐ right lower	
		b3. ☐ left upper	
		b4. ☐ left lower	
		c. Rhonchi	
		c1. ☐ right upper	
		c2. ☐ right lower	
		c3. ☐ left upper	
		c4. ☐ left lower	
		d. ☐ Wheezes	
		e. Diminished	
		e1. ☐ right upper	

3. Respiratory

Lung Sounds

e2. ☐ right lower

e3. ☐ left upper

e4. ☐ left lower

f. Absent

f1. ☐ right upper

f2. ☐ right lower

f3. ☐ left upper

f4. ☐ left lower

g. Does the resident exhibit any Shortness of Breath (dyspnea) ○ 0. No ○ 1. Yes

h. Cough ○ 1. None ○ 2. Non-productive ○ 3. Productive

Respiratory Care Needs - Check all that currently apply:

i1. ☐ Suctioning

i2. ☐ Chest tube

i3. ☐ Heimlich valve

i4. ☐ Ventilator

i5. ☐ CPAP/BIPAP

i6. ☐ Hand held nebulizer

i7. ☐ Oxygen

If on oxygen,

i7a. Liter flow or % _____

i7b. Via ○ 1. nasal cannula ○ 2. mask

i8. ☐ Tracheostomy

If tracheostomy,

i8a. Type ○ 1. cuffed ○ 2. uncuffed

j. Respiratory Section Comments

4. Gastrointestinal

a. Nutrition (Braden)
4) Excellent - eats most of every meal and requires no supplements.
3) Adequate - eats over half of most meals or is on tube feeding.
2) Probably Inadequate - eats only about half of any food offered.
1) Very Poor - rarely eats more than a third of foods offered or is NPO, on clear liquids or IV for five or more days.

Current Toileting Method (Bowel) - Check all that apply:

b1. ☐ bathroom

b2. ☐ commode

b3. ☐ bedpan

c. Dentures or removable bridge

○ 1. Not present ○ 2. Present ○ 3. UTD

If dentures present,

c1. ☐ Upper dentures full

c2. ☐ Upper dentures partial

c3. ☐ Lower dentures full

c4. ☐ Lower dentures partial

c5. Do dentures fit properly?

4. Gastrointestinal

○ 0. No ○ 1. Yes ○ 3. UTD

d. ☐ Chooses not to wear dentures

e. Dental - Check all that currently apply:

e1. ☐ Broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose)

e2. ☐ No natural teeth or tooth fragment(s) (edentulous)

e3. ☐ Abnormal mouth tissue (ulcers, masses, oral lesions, including under denture or partial if one is worn)

e4. ☐ Obvious or likely cavity or broken natural teeth

e5. ☐ Inflamed or bleeding gums or loose natural teeth

e6. ☐ Mouth or facial pain, discomfort or difficulty with chewing

e7. ☐ Unable to examine

f. Swallowing Disorder - Signs and symptoms of possible swallowing disorder. Check all that currently apply:

f1. ☐ Loss of liquids/solids from mouth when eating or drinking

f2. ☐ Holding food in mouth/cheeks or residual food in mouth after meals

f3. ☐ Coughing or choking during meals or when swallowing medications

f4. ☐ Complaints of difficulty or pain when swallowing

Current Complaints/Symptoms - Check all that currently apply:

g1. ☐ Constipation

g2. ☐ Diarrhea

g3. ☐ Nausea/ vomiting

g4. ☐ Distension

g5. ☐ Flatulence

g6. ☐ Heartburn

g7. ☐ Rectal bleeding

g8. ☐ Bowel Incontinence

h. ☐ Ostomy (including urostomy, ileostomy, and colostomy)

If yes, type

h1. ☐ Ileostomy

h2. ☐ Colostomy

j. Is a toileting program currently being used to manage the resident's bowel continence?

○ 0. No

○ 1. Yes

○ -. Not assessed/no information

k. Feeding Tube - Check Feeding tube, if a feeding tube was used since admission:

k1. ☐ Feeding tube - nasogastric or abdominal (PEG)

k1a. If Yes, type

○ 1. NG ○ 2. PEG ○ 3. G-tube ○ 4. J-tube

l. Bowel sounds

○ 1. Not present ○ 2. Present ○ 3. UTD

m. Date of last bowel movement

n. Gastrointestinal Section Comments

4. Gastrointestinal

5. Genitourinary

Current Toileting Method (Urinary) - Check all that apply:

a1. ☐ bathroom

a2. ☐ commode

a3. ☐ bedpan

a4. ☐ urinal

Appliances - Check all that currently apply:

b1. ☐ Indwelling catheter (including suprapubic catheter and nephrostomy tube)

b1a. If indwelling catheter other than a foley, specify type:

○ 1. suprapubic ○ 2. nephrosotomy

b1b. If yes, reason for catheter:

b2. ☐ External catheter

b3. ☐ Ostomy (including urostomy, ileostomy, and colostomy)

b4. ☐ Intermittent catheterization

b4a. If intermittent catheterization checked, enter frequency

b4b. If intermittent catheterization checked, enter last time catheterized.

b5. ☐ Pessary

Current Complaints/Symptoms - Check all that apply:

c1. ☐ Frequency

c2. ☐ Burning

c3. ☐ Difficulty starting

c4. ☐ Urgency

c5. ☐ Flank pain

c6. ☐ Nocturia

c7. ☐ Itching

c8. ☐ Urinary Incontinence

d. Current toileting program or trial - Is a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) currently being used to manage the resident's urinary continence?

○ 0. No

○ 1. Yes

○ -. Not assessed/no information

Dialysis

e1. If receiving dialysis, what type

○ 1. hemodialysis ○ 2. peritoneal

e2. Select access

5. Genitourinary

1) fistula
2) graft
3) external catheter

e3. Enter location

f. **Genitourinary Section Comments**

6. Musculoskeletal

a. Mobility (Braden)
4) No Limitations - changes position without assistance
3) Slightly Limited - needs limited assistance to change position
2) Very Limited - unable to make significant changes in position independently, needs extensive assistance
1) Completely Immobile - does not make even slight changes in body position by self

a1. Assistance required?
- 0. No
- 1. Yes

b. Activity (Braden)
4) Walks Frequently - walks at least every 2 hours while awake
3) Walks Occasionally - walks very short distances, spends majority of shift in bed/chair
2) Chairfast - cannot bear own weight, must be assisted into chair
1) Bedfast - confined to bed

c. Friction and shear (Braden)
3) No Apparent Problem - does not slide down in chair or bed and has sufficient muscle strength to lift self during position change
2) Potential Problem - slides down in chair or bed occasionally, does not lift up completely during move
1) Problem - frequently slides down in chair or bed or has spasticity/contractures

d. **Mobility Devices - Check all that were normally used since admission:**

d1. ☐ Cane/crutch
d2. ☐ Walker
d3. ☐ Wheelchair (manual or electric)
d4. ☐ Limb prosthesis

Functional Limitation in Range of Motion - Answer items e. & f. for the period since admission

e_f. *Code for limitation that interfered with daily functions or placed resident at risk of injury*

e. Upper extremity (shoulder, elbow, wrist, hand)
- 0. No impairment
- 1. Impairment on one side
- 2. Impairment on both sides
- -. Not assessed

e1. If impairment on one side
- 1. Right
- 2. Left

f. Lower extremity (hip, knee, ankle, foot)
- 0. No impairment
- 1. Impairment on one side
- 2. Impairment on both sides
- -. Not assessed

f1. If impairment on one side
- 1. Right
- 2. Left

Current Extremity Weakness

6. Musculoskeletal

g1. ☐ No extremity weakness
g2. ☐ Right arm
g3. ☐ Left arm
g4. ☐ Right leg
g5. ☐ Left leg

Other conditions - Check all that apply:

h1. ☐ Joint swelling
h1a. *If checked, location*

h2. ☐ Contractures

If contractures,

h2a. ☐ *RU extremity*
h2b. ☐ *RL extremity*
h2c. ☐ *LU extremity*
h2d. ☐ *LL extremity*
h3. ☐ Amputation
h3a. *If amputation, location*
h3b. ☐ If amputation, prosthesis
h3c. *If prosthesis, type and location*
h4. ☐ Device/cast/splint
h4a. *If device/cast/splint, location*

i. Functional Rehabilitation Potential

i1. Resident believes he or she is capable of increasing independence in at least some ADLs
- ○ 0. No
- ○ 1. Yes
- ○ 9. Unable to determine
- ○ -. Not assessed

i2. Consult Rehab, if the response to the question above (i1.) is Yes.

j. Musculoskeletal Section Comments

7. Integumentary

a. Moisture (Braden)
4) Rarely Moist - usually dry
3) Occasionally Moist - incontinent daily, but infrequent exposure (e.g., night incontinence, but use of padding systems)
2) Very Moist - incontinent once a shift
1) Constantly Moist - moist nearly all the time (e.g., constant dribbling and/or perspires excessively)

b. Skin color
1) Normal for ethnicity
2) Pale
3) Cyanotic / Dusky
4) Jaundiced
5) Not applicable

c. Skin condition

7. Integumentary

1) Warm
2) Cool
3) Dry
4) Moist

d. Skin impairment(s) including Foot Problems, Surgical Wounds and Burns

○ 1. Not present ○ 2. Present ○ 3. Not applicable

If present, indicate location, type and description. Initial screen only, all skin issues must be further assessed and measured by initiating corresponding skin assessment.

d1. Site:

d2. Site:

d3. Site:

d4. Site:

d5. Site:

d6. Site:

d7. Site:

7.	Integumentary	**d8.** Site: **d9.** Site: **d10.** Site: **d11.** Site: **d12.** Site: **d13.** Site: **d14.** Site: Current IV Device(s) - Check all that apply: **e1.** ☐ Peripheral **e2.** ☐ PICC **e3.** ☐ Implanted port **e4.** ☐ Midline **e5.** ☐ Central

7.	Integumentary	**e6.** ☐ External hemodialysis catheter **e7.** For Central or PICC line, date position verified Other Devices currently used: **f.** Drains ○ 0. No ○ 1. Yes **f1.** If drains, select type ○ 1. penrose ○ 2. hemovac ○ 3. bulb ○ 4. t-tube ○ 5. other **f2.** Drain location(s) **g.** Wound vac/negative pressure present? ○ 0. No ○ 1. Yes **g1.** If yes, location **h.** Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. **h1.** Restraints used? ○ 0. No ○ 1. Yes **i.** **Integumentary Section Comments**